STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council
Design Group 2 – Payment Calculation and Distribution
Design Workshop #2

Meeting Summary
Thursday, March 19th, 2015
12:00 – 1:00 p.m.

Location: By Webex and Conference Call

Members Present: Christopher Borgstrom; Arnold DoRosario; Gaye Hyre; Keith vom Eigen

Other Participants: Steve Frayne; Katie Sklarsky; Adam Stolz

Agenda Items:
1. **Introductions**
2. **Public Comment**
3. **Overview of Design Group Process**
4. **Discussion of Payment Calculation and Distribution**
5. **Synthesis of Initial Hypotheses**

Meeting Summary:

The meeting was called to order at 12:00pm.

Katie Sklarsky facilitated a group discussion. Participants articulated a number of perspectives including:

Payment Calculation (How Payers Pay ACOs)
- Terminology: meeting a minimum quality target in order to be eligible to earn shared savings will be referred to as a Quality Threshold, rather than a Quality Gate.
- Several clarifications and edits were requested to the proposed payment calculation hypothesis and related potential recommendations to more directly link payment calculation with any under-service implications.
    - Proposed Hypothesis: It was noted that the hypothesis would be more applicable in a capitated environment. In a FFS/shared savings environment, especially upside only, providers are not under financial "pressure" per se to hit cost targets. Rather, they have an opportunity to earn additional payments by hitting cost targets.
    - Quality Incentive Recommendation: The group agreed with the notion that some incentive payments should be distributed when providers hit quality targets, even if they don't hit cost targets. The potential equity and access implication of doing this is that rewarding providers for quality, irrespective of cost outcomes, will help incent provision of the most appropriate care, even if it's more expensive than an alternative method.
    - Minimum Savings Rate (MSR): The group felt that utilizing no MSR or a very low MSR (i.e. 1%) in the early years of a shared savings program would potentially reduce any incentive to stint on care in an attempt to hit an MSR. Any savings achieved should be shared with providers (assuming quality/performance targets are met). Earning a portion of the amount an ACO saves, even at low levels, rather than earning "all or nothing" by virtue of an MSR, is both consistent with the goal of

deterring under-service and also provides additional resources for ACOs to invest in capabilities.
    - Reinvestment: The group revisited the question of what happens to savings that ACOs achieve but don't earn because of an MSR. Previously the idea emerged in the Design Group that such funds should be earmarked for reinvestment in provider capabilities. While the group felt that this makes sense from a provider's standpoint and may yield benefits for access (depending on how the funds are spent), a direct link to patient selection or under-service was not expressed.
- The group discussed several new ideas.
    - An ACO's shared savings eligibility should be related to improved quality performance, not just absolute quality performance
        - Group suggested the idea of defining a threshold, target, and stretch goal for quality performance. Performance against those goals could be associated with a point system that determines how much of the savings the provider is rewarded. This is similar to what Medicare does with MSSP currently.
    - Use of the improvement method (i.e. measuring performance based on improvement over the prior year as opposed to performance as compared to peers) to assess performance. This type of incentive system could be structured as follows:
        - A unique threshold, target and stretch goal would be established for each ACO based on the prior year's performance.
        - This would account for any inherent risk of the population that might make quality goals more difficult to achieve as compared to other ACOs with populations that do not have those risks.
        - It would also provide the opportunity for both lower and higher performing ACOs to achieve more savings if large quality improvements are demonstrated as defined by achieving the uniquely identified stretch goal.
        - As a note, some quality measures may not be able to be improved upon further once best practice is reached (i.e. 100% of patients receive the flu vaccine). In this instance the stretch goal would be to maintain performance.
        - The implication for under-service and patient selection is that, by measuring providers' quality against their own historical performance, providers who serve a more complex population that is more challenging to manage will not be penalized. In turn, the related incentive to avoid more challenging patients will be eliminated.

Payment Distribution (How ACOs Pay Provider Groups and Providers)

- For the distribution of savings, individual provider groups/individual providers should be rewarded based only on quality performance weighted by the number of attributed lives on their panel, not the amount of savings generated by the individual provider.
- Payers should publicly disclose the methodology behind quality measurement to promote transparency around the standards that are being used to determine payments to ACOs. ACOs should also disclose their provider payment methodologies.

Issues Surfaced To Be Addressed Outside Design Group

- The group discussed policies and pending legislation that may have a broader impact on the SIM initiatives that are seeking to transform the delivery system. To the extent these issues are out of scope for the EAC, there may be other areas of the SIM governance structure through which to address them. To the extent the issues have equity and access implications related to SIM initiatives, and are out of scope for EAC Phase 1 but may be time sensitive, the EAC can consider whether and how to address these.

The meeting adjourned at 1:07pm.